Admission Requirements

Critical Access Hospital
SWING BED REFERENCE GUIDE, Fourth Edition

Patient must meet all of the following:

- Eligible for Part A and have SNF benefit days available to use.
- Three-day (three midnights) qualifying stay.
- Services are for a condition treated during the qualifying stay, ***or*** which arose while in the swing bed unit for treatment of a condition previously treated during the qualifying stay.
- Services are provided within thirty (30) days of discharge from:
  - An acute inpatient bed in the swing bed hospital; or
  - Discharge from another acute hospital; or
  - Discharge from a swing bed or skilled nursing facility.
- Services can only be provided on an inpatient basis in a SNF or swing bed.

Requires one or more of the following services

or one or more of the following services

Skilled Nursing Care (7 days per week)

- Management and evaluation of a patient care plan (see Colorado Rural Health Center Swing Bed Manual).
- Observation and assessment until the patient's treatment regimen is stabilized (see Colorado Rural Health Center Swing Bed Manual).
- Intravenous or intramuscular injections or intravenous feeding.
- Insertion, sterile irrigation, replacement and care of suprapubic catheters.
- Nasogastric tube, gastrostomy, or jejunostomy feedings equal to 26% of daily calories and a minimum of 501 ml of fluid per day.
- Naso-pharyngeal and tracheotomy aspiration.
- Application of dressings with prescription medications and aseptic technique.
- Treatment of decubitus ulcers (Grade 3 or worse) or widespread skin disorder.
- Heat treatments ordered by a physician requiring observation to evaluate patient's progress.
- Initial phases of a regimen involving administration of medical gases, such as bronchodilator therapy.
- Professional observation when the patient's condition requires 24 hour nursing supervision, including:
  - Medical conditions such as uncontrolled diabetes or acute congestive heart failure episodes; or
  - Vital sign monitoring for special purposes, such as when the patient is on specific medications; or
  - Psychiatric conditions such as depression, anxiety, suicidal behavior, etc.
- Institution and supervision of bowel and bladder training program.
- Colostomy or ileostomy care in the early postoperative period in the presence of associated complications.
- Teaching or Training Activities:
  - Self-administration of injectable medications.
  - A new diabetic to administer insulin, prepare and follow a diabetic diet, observe foot-care precautions.
  - Care for a recent colostomy or ileostomy.
  - Self-administration of medical gases.
  - Gait training and prosthesis care to a recent leg amputee.
  - Self-catheterization and self-administration of gastrostomy feedings, care and maintenance.
  - Care and maintenance of central venous lines or Hickman catheter.
  - Care of braces, splints, orthotics, and associated skin care.
  - Specialized dressings and skin care.

Skilled Rehabilitative Services (at least 5 days per week):

- Assessment, (initial and ongoing) of a patient's rehabilitation needs and potential.
- Gait evaluation and training when the ability to walk has been impaired.
- Therapeutic exercises which, as a result of the type of exercise, or the condition of the patient, require supervision of a skilled physical therapist.
- Range of motion test and range of motion exercises when part of active treatment for a specific condition.
- Ultrasound, short-wave, diathermy.
- Occupational therapy with the objective of improving or restoring impaired or lost function resulting from illness or injury.
- Design/fabrication and fitting of orthotics or self-help devices;
- Services for the treatment of dysphagia;
- Maintenance therapy if it involves complex, sophisticated procedures requiring the judgment and skill of a physical therapist to ensure safety and effectiveness of the therapy;

*The following are **Non-Skilled Services**. If these are the only level of service being provided, the patient would not meet level of care requirements for swing bed admission.*

- Administration of oral medications, eye drops, & ointments.
- General maintenance care of colostomy or ileostomy.
- Routine services to maintain functioning of indwelling catheters.
- Dressing changes for non-infected postoperative or chronic conditions.
- Prophylactic and palliative skin care.
- General maintenance care in connection with a plaster cast.
- Routine care of an incontinent patient, including diapers and protective sheets.
- Routine care in connection with braces or similar devices.
- Use of heat as a palliative or comfort measure, such as whirlpool or steam pack.
- Periodic turning and positioning in bed.
- General supervision of exercises taught to the patient or performance of repetitious exercises.
- Routine administration of medical gases after a regimen of therapy has been established.
- Assistance in dressing, eating and going to the toilet.
- Preparation of special diets.

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Instructions for Transfers from Other Acute Care Hospitals

- Verify the payment source.
- Identify the receiving attending physician, arrange physician to physician contact if possible.
- Arrange therapist to therapist, or nurse to nurse contact to review required services and determine level of care.
- Verify that the patient is stable and appropriate for swing bed admission.
- Identify special equipment needs (lifts, specialized beds, etc).
- Verify the patient meets admission requirements described on the previous page.
- Identify special staffing needs.
- Identify the medications required by the patient and determine availability through the hospital formulary.
- Verify patient understanding, willingness, and ability to participate in a treatment program.

Care Assessment

Comprehensive assessments and comprehensive care plans must be completed for patients admitted to swing beds. It is suggested that the comprehensive assessment should be completed within 24– 48 hours of admission.

Elements of the comprehensive assessment include:

- Activity Pursuit
- Cognitive Patterns
  - Evaluation of the patient's ability to make decisions, including health care decisions, and his/her ability to participate in treatment activities.
  - An assessment of the patient's ability to problem solve, make decisions and respond to potential safety hazards.
- Communication
- Continence
- Customary Routine
  - The patient's ability to perform Activities of Daily Living (ADLs) including eating, drinking, bathing, dressing, grooming, transferring, ambulating, toilet use, and ability to speak or use communicative devices and language needs.
  - Assessment of the patient's ability to participate in activities aside from the ADLs. This should take into consideration the patient's normal everyday routines and activities that contribute to financial or emotional independence, pleasure, comfort, education, success, etc.
- Dental and Nutritional Status
  - Evaluation of eating habits or preferences, and dietary restrictions, if any.
  - An evaluation of the condition of the patient's teeth, gums and oral cavity, particularly as these affect the patient's ability to eat and maintain nutritional status; and communicate with others, including family and health care providers. If the patient has, uses or needs dentures or other dental appliances, this should be noted.
- Discharge Potential
  - An assessment of the patient's discharge potential and projected length of stay.
- Disease Diagnoses and Health Conditions
  - A description of the patient's current medical diagnoses, including any history of mental retardation or current mental illness.
  - Objective information about the patient's current physical and mental status/abilities, including vital signs, clinical laboratory values or diagnostic tests.
  - Height, weight, and observation of the patient's nutritional status or needs.
- Documentation of participation in assessment
- Documentation of Summary Information regarding the additional assessment performed through the resident assessment protocols
- Identification and Demographic Information
- Medications
  - An evaluation of the over-the-counter and prescription drugs taken by the patient; including dosage, frequency of administration, potential drug interactions and allergies, and recognition of significant side effects most likely to occur.
- Mood and Behavior Patterns
- Psychosocial Well Being
  - Description of the patient's ability to deal with life, interpersonal relationships, goals and ability to make health care decisions, as well as overall mood and behavior.
- Physical Functioning and Structural Problems
  - Information about any sensory or physical impairments the patient may have, such as loss of hearing, poor vision, speech impairments, difficulty swallowing, loss of bladder or bowel control, etc.
  - An evaluation of the potential need for staff assistance or assistive devices, or equipment; including walking aids, dentures, hearing aids or glasses.
  - The patient's ability to improve his/her level of functional status and independence through rehabilitation programs.
- Skin Condition
- Special Treatments and Procedures
  - Assessment of the need for specialized skilled services such as skin care for decubitus; nasogastric feedings; or respiratory care.
- Vision

For more information about requirements related to the comprehensive care plan, see the Idaho Swing Bed Manual.

Discharge Summary

Elements of the discharge summary include:

- A summary of the patient's stay in the swing bed and the services received.
- The patient's destination upon discharge.
- A summary of the patient's health care status at the time of discharge.
- A post discharge plan of care.

Idaho
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208-604-2615